

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program

Screening, Brief Intervention, and Referral to Treatment (SBIRT).....	2
Program Overview	2
Billing Information.....	2
National Provider Identifier (NPI).....	2
Paper Claims	2
Electronic Claims	3
Key Clinical Definitions	3
Pre-Screen (aka Brief Screen).....	3
Full Screen	3
Brief Intervention	4
Follow-Up.....	4
Referral.....	4
Member Eligibility	5
Eligible Providers	5
Training Requirements for Licensed and Unlicensed Health Care Professionals	5
Billing Information.....	6
Procedure Code Overview	6
National Correct Coding Initiative (NCCI) Edits for SBIRT	6
Screening and Brief Intervention Procedure Codes.....	7
SBIRT Screening Reimbursement Codes.....	8
Diagnosis Codes	9
Emergency Department	10
Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHC)	10
Additional Policies.....	10
Member Benefit Limitations	10
Reimbursement	11
CMS 1500 Paper Claim Reference Table.....	11
Late Bill Override Date.....	23
CMS 1500 SBIRT Claim Example.....	28
Resources:	29

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Program Overview

The Colorado Medical Assistance Program only reimburses providers for medically necessary services furnished to eligible members.

The purpose of this billing manual is to provide policy and billing guidance to providers to obtain reimbursement for SBIRT services. This manual is updated periodically to reflect changes in policy and regulations.

Screening, Brief Intervention, and Referral to Treatment is designed to prevent members from developing a substance use disorder, for early detection of a suspected substance use disorder, or to refer members for treatment. These services are not intended to treat members already diagnosed with a substance use disorder or those members already receiving substance use disorder treatment services. Members who are pregnant may be eligible for additional substance use screening and intervention services through [Special Connections](#), Outpatient Substance Use Disorder treatment, and the [Prenatal Plus program](#).

Treatment referrals must be made to the members regional Behavioral Health Organization (BHO). Please visit the [BHO](#) web page for contact information and further details.

Billing Information

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities (e.g., health plans, health care clearinghouses, and those health care providers that transmit any health information electronically in connection with a transaction for which the Secretary of Health and Human Services has adopted a standard) use NPIs in standard transactions.

Paper Claims

Electronic claims format shall be required unless hard copy claims submittals are specifically prior authorized by the Department of Health Care Policy and Financing (the Department). Requests for paper claim submission may be sent to the Xerox State Healthcare, P.O. Box 90, Denver, CO 80201-0090. The following claims can be submitted on paper and processed for payment:

- Claims from providers who consistently submit five (5) claims or fewer per month (requires prior approval)
- Claims that, by policy, require attachments
- Reconsideration claims

Paper claims do not require an NPI, but do require the Colorado Medical Assistance Program provider number. Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required."

Electronic Claims

Instructions for completing and submitting electronic claims are available through the following:

- X12N Technical Report 3 (TR3) for the 837P, 837I, or 837D (wpc-edi.com/)
- Companion Guides for the 837P, 837I, or 837D in the Provider Services [Specifications](#) section of the Department's website.
- Web Portal User Guide (via within the portal)

The Colorado Medical Assistance Program collects electronic claim information interactively through the Colorado Medical Assistance Program Web Portal ([Web Portal](#)) or via batch submission through a host system.

For additional electronic information, refer to the General Provider Information manual located on the [Billing Manuals](#) web page.

Key Clinical Definitions

Pre-Screen (aka Brief Screen)

A pre-screen is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "a rapid, proactive procedure to identify individuals who may have a condition or be at risk for a condition before obvious manifestations occur." It involves short questions relating to alcohol and drug use, and must be administered prior to beginning a full screening. Pre-screens are considered part of routine medical management and are not a separately reimbursable service.

Full Screen

Full screens are administered after a member has answered positively to the pre-screen questions. Full screens entail asking members a validated series of questions to assess the level of a member's substance use. Full screens are only covered for members with positive brief screens and for members with signs, symptoms, and medical conditions that suggest risky or problem alcohol or drug use.

Full screenings should be used as a primary method for educating members about the health effects of using alcohol and other drugs. Colorado Medicaid covers screening services in a wide variety of settings to increase the chance of identifying individuals at risk for future substance abuse.

Providers are required to use an evidence-based screening tool to identify members at risk for substance use problems. The screening tool should be simple enough to be administered by a wide range of health care professionals. The tool must demonstrate sufficient evidence of validity and reliability to accurately identify members at potential risk for substance use disorder. Enough information must be generated from utilizing the tool to customize an

appropriate intervention based on the identified level of substance use. Providers may use more than one screening tool during the screening process if appropriate; however, no additional reimbursement will be made.

Colorado Medicaid has approved several evidence-based screening tools and will update the list as new methods become available.

The current approved evidence-based screening tools are:

- The Alcohol Use Disorders Inventory Test (AUDIT)
- The Drug Abuse Screening Test (DAST)
- The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- The Car, Relax, Alone, Forget, Friends, Trouble Screening Test (CRAFT), which has been validated for adolescents
- The Problem Oriented Screening Instrument for Teenagers (POSIT)

Brief Intervention

Brief interventions are interactions with members that are intended to induce a change in a health-related behavior. Often one (1) to three (3) follow-up contacts are provided to assess and promote progress and to evaluate the need for additional services. Brief interventions are typically used as a management strategy for members with risky or problem alcohol or drug use who are not dependent. This includes members who may or may not qualify for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) diagnosis of alcohol or drug abuse.

Brief substance use intervention services are covered for members who, through the use of an evidence-based screening tool, are identified as at-risk for a substance use disorder(s). Brief intervention may be single or multiple sessions to increase insight and awareness regarding substance use and motivation for changes in behavior. Alternatively, a brief intervention may also be used to increase motivation and acceptance of a referral for substance use treatment. Intervention services may occur on the same date of service as the screening or on a later date. Brief intervention is not covered prior to screening.

Providers are required to use effective strategies for counseling and intervention. Examples of demonstrated effective strategies include the following:

- The [SBIRT protocols](#)
- "[Helping Patients Who Drink Too Much: A Clinician's Guide](#)," Updated 2005 Edition

Follow-Up

Follow-up services include interactions that occur after initial intervention, treatment, or referral services, and are intended to reassess a member's status, assess a member's progress, promote or sustain a reduction in alcohol or drug use, and/or assess a member's need for additional services.

Referral

Members who appear to be alcohol- or drug-dependent are typically referred to alcohol and drug treatment programs. Treatment referrals must be made to the member's regional

Behavioral Health Organization (BHO). Please visit the [BHO](#) web page for contact information and further details.

Member Eligibility

The SBIRT benefit is available to members ages 12 and older who are enrolled in the Colorado Medical Assistance Program. Members enrolled in a Medicaid HMO or managed care organization (MCO) must receive SBIRT services through the HMO or MCO.

Eligible Providers

The following licensed providers are eligible to provide SBIRT or supervise staff who provide SBIRT:

- Physician/psychiatrist
- Psychologist, Psy.D / Ph.D
- Masters level clinicians:
 - a. Licensed clinical social worker (LSCW)
 - b. Licensed marriage and family therapist (LMFT)
 - c. Licensed professional counselor (LPC)
- Nurse Practitioner
- Physician Assistant

Non-licensed providers may deliver SBIRT under the supervision of a licensed provider if such supervision is within the legal scope of practice for that licensed provider.

Providers must be enrolled in the Colorado Medical Assistance Program in order to:

- Treat a Medicaid member; and
- Submit claims for payment to the Colorado Medical Assistance Program.

Training Requirements for Licensed and Unlicensed Health Care Professionals

In order to directly deliver screening and intervention services, providers are required to participate in a training that provides information about the implementation of evidence-based protocols for screening, brief interventions, and referrals to treatment. Face-to-face trainings and consultations are available through various entities such as [SBIRT Colorado](#), [Health TeamWorks](#), [Colorado Community Managed Care Network](#), and the [Emergency Nurses Association](#). Online SBIRT Training: The *Substance Use SBIRTmentor* is an interactive, online training opportunity. The training offers three (3) continuing education credits and can be accessed at [CMEcorner.com/SBIRT](#). This skills-based training was developed in collaboration with the SBIRT Colorado initiative, Peer Assistance Services, Inc., MedRespond, and NORC at the University of Chicago. Other online training modules can be found at [sbirttraining.com/SBIRT-Core](#)

Unlicensed health care professionals must complete a minimum of 60 hours of professional training (e.g. education) that includes a minimum of four (4) hours of training directly related to SBIRT **and** 30 hours of face-to-face member contact (e.g. practicum or internship) ***within their respective fields***, prior to providing SBIRT services under the supervision of a licensed health care professional.

All providers are required to retain documentation confirming that staff providing SBIRT meet the training, education, and supervision requirements.

Billing Information

The procedure codes used to report SBIRT services for reimbursement are consistent among all provider types. This section will provide a comprehensive overview of the elements necessary to report SBIRT services in various billing scenarios. A provider may not submit a claim containing both Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) codes. The provider must use **either** the CPT **or** the HCPCS codes designated for SBIRT services.

Procedure Code Overview

Colorado Medicaid accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The procedure codes are used to submit claims for services provided to Colorado Medicaid members and represent services that may be provided by enrolled certified Colorado Medicaid providers.

The Healthcare Common Procedural Coding System (HCPCS) are divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT, a numeric coding system maintained by the American Medical Association (AMA).

The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits.

The Health Insurance Portability & Accountability Act requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one unit or session. Providers should regularly consult monthly bulletins located on the [Bulletins](#) web page. To receive electronic provider bulletin notifications, an email address can be entered into the [Web Portal](#) in the *(MMIS) Provider Data Maintenance* area or by completing and submitting a publication preference form. Bulletins include updates on approved procedure codes as well as the maximum allowable units billed per procedure.

National Correct Coding Initiative (NCCI) Edits for SBIRT

National Correct Coding Initiative (NCCI) Procedure-to-procedure (PTP) billing edits affect SBIRT codes. When applicable, attach bypass modifiers (typically 25 or 59) to H0049, 99408, and 99409 line items to indicate that a separate amount of time was spent conducting the SBIRT process from other office procedures. Not all code pairings may be unbundled using a bypass modifier. Please refer to the [Medicaid NCCI website](#) for further instruction on bypass modifier use.

Screening and Brief Intervention Procedure Codes

- **Procedure code 99408** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; 15-30 minutes.
- **Procedure code 99409** - Alcohol and/or substance use structured screening (e.g., AUDIT, DAST, CRAAFT), and brief intervention services; greater than 30 minutes.

Screening and Brief Intervention Coding & Billing Requirements					
Procedure Code	Description	Modifier	Potential Diagnosis	Unit of Service	Prior Authorization Required
99408	Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services; 15 to 30 minutes.	<i>Modifier 59 may be applied to bypass NCCI edits.</i>	Z71.41 Z71.42 Z71.51 Z71.52 Z71.6	Limit one per day, two per state fiscal year.	No PA
99409	Alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services; greater than 30 minutes.	<i>Modifier 59 may be applied to bypass NCCI edits.</i>	Z71.41 Z71.42 Z71.51 Z71.52 Z71.6	Limit one per day, two per state fiscal year.	No PA

Clinical guidance for procedure codes 99408 and 99409:

Screening and brief intervention describes a different type of member-physician interaction than the provision of general advice. It requires a significant amount of time and additional acquired skills to deliver. Screening and brief intervention techniques are discrete, clearly distinguishable clinical procedures that are effective in identifying problematic alcohol or substance use.

Components include but are not limited to:

- Using a standardized screening tool;
- Providing feedback to the member on the screening results;
- Discussing negative consequences that have occurred and the overall severity of the problem;
- Motivating the member toward behavioral change;
- A joint decision-making process regarding alcohol and/or drug use; and
- Discussing and agreeing on plans for follow up with member.

Ancillary staff, including health educators, may perform SBIRT services under the supervision of a credentialed provider. The services should relate to a plan of care and will require billing under the supervising physician. **SBIRT screening and brief intervention that does not meet the minimum 15 minute threshold is not separately reimbursable.** These are time-based codes, therefore documentation must denote start/stop time or total face-to-face time with the member. Due to procedure code 99409 being inclusive of the time spent before 30 minutes is accumulated, the two procedure codes may not be billed together on the same date of service. Both procedure codes account for screening *and* brief intervention, therefore state fiscal yearly limits for *screening* and *brief intervention* apply to each.

Procedure code 99408 / procedure code 99409 may only be billed when all these conditions are met:

1. When they follow a positive pre-screen;
2. When a full screen is positive; and
3. When they account for the time of full screening, brief intervention, and/or referral to treatment.

*Note: The state fiscal year is July 1st through June 30th.

SBIRT Screening Reimbursement Codes

Procedure code H0049 - Alcohol and/or drug screening, (untimed):

Screening Coding & Billing Requirements					
Procedure Code	Description	Modifier	Potential Diagnosis	Units of Service	Prior Authorization Required
H0049	Alcohol and/or drug screening (e.g. AUDIT, DAST, CRAFFT, etc.)	<i>Modifier 59 may be applied to bypass NCCI edits.</i>	Z13.9	Limit one (1) per day, two (2) per state fiscal year.	No PA

A full screen will frequently be negative and the member will not require brief intervention or referral to treatment. These instances are still reimbursable using the HCPCS procedure code H0049. When using procedure code H0049, a unit of service is equivalent to the total amount of time required to administer the screening. Therefore, when billing the screening the units of service should always equal one (1) regardless of time spent completing the screening.

Procedure code H0049 may only be billed when all these conditions are met:

1. It followed a positive pre-screen;
2. The full screen was negative; and
3. A brief intervention or referral to treatment was not necessary.

Procedure code H0049 may not be billed in conjunction with procedure code 99408 or procedure code 99409 because those two (2) codes are also inclusive of a full screening.

Diagnosis Codes

Diagnosis codes play a critical role in supporting the medical necessity of the CPT or HCPCS codes that are billed. Below are tables of common diagnosis codes for reporting SBIRT services, and codes for reporting the allowable places of service for providing SBIRT services.

Common ICD-10 Codes Used for SBIRT	
Z13.9	Encounter for screening, unspecified
Z36	Encounter for antenatal screening of mother
Z71.9	Counseling, unspecified
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.42	Counseling for family member of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.52	Counseling for family member of drug abuser
Z71.6	Tobacco abuse counseling
Z32.2	Encounter for childbirth instruction
Z32.3	Encounter for childcare instruction
Z69.81	Encounter for mental health services for victim of other abuse
Z70.0	Counseling related to sexual attitude
Z70.1	Counseling related to patient's sexual behavior and orientation
Z70.2	Counseling related to sexual behavior and orientation of third party
Z70.3	Counseling related to combined concerns regarding sexual attitude, behavior and orientation
	Other sex counseling
	Sex counseling, unspecified

Common ICD-10 Codes Used for SBIRT	
Z70.8	Spiritual or religious counseling
Z70.9	Other specified counseling
Z71.81	Person encountering health services in other specified circumstances
Z71.89	
Z76.89	

Allowable Place of Service Codes	
03	School
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
99	Other Place of Service

Emergency Department

SBIRT that is provided in the hospital emergency department may be billed directly to the Colorado Medical Assistance Program by the rendering physician or may be included in the hospital claim, *but never both*.

Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHC)

Reimbursement for SBIRT is included in the encounter rate payment. No separate reimbursement for SBIRT is allowable in these settings.

Additional Policies

1. Screening Brief Intervention Treatment is not designed to address smoking and tobacco cessation services unless it is a co-occurring diagnosis with another substance such as drugs or alcohol. Tobacco-only services are not a SBIRT billable benefit.
2. Screening Brief Intervention Treatment must be provided face-to-face with the member or via simultaneous audio and video transmission (telemedicine) with the member.
3. A physician order, referral, or prescription is not required for any component of SBIRT.
4. A prior authorization request is not required.

Member Benefit Limitations

1. Up to two (2) full screens per state fiscal year.
2. Up to two (2) sessions of brief intervention/referral per state fiscal year.

Reimbursement

Reimbursement for SBIRT services will be made at the lesser of the provider's usual and customary charge or the Colorado Medicaid maximum allowable fee for the service. Colorado Medicaid will pay for separate and additional services on the same day as SBIRT, including medically necessary E&M services. The SBIRT codes will not be separately reimbursed when billing under the Mental Health and Substance Use Disorder Screening benefit using procedure codes H0002 and H0004, or with any other HCPCS or CPT code that represents the same or similar services. Claims cannot be submitted using combined CPT and HCPCS codes designated for SBIRT services (e.g. procedure code 99408 *and* procedure code H0049).

CMS 1500 Paper Claim Reference Table

The following table shows required, optional, conditional fields, and detailed field completion instructions for the CMS 1500 paper claim form.

CMS Field #	Field Label	Field is?	Instructions
1	Insurance Type	Required	Place an "X" in the box marked as Medicaid.
1a	Insured's ID Number	Required	Enter the member's Colorado Medical Assistance Program seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	Patient's Name	Required	Enter the member's last name, first name, and middle initial.
3	Patient's Date of Birth / Sex	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the member.
4	Insured's Name	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's full last name, first name, and middle initial. If the insured used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.

CMS Field #	Field Label	Field is?	Instructions
5	Patient's Address	Not Required	
6	Patient's Relationship to Insured	Conditional	Complete if the member is covered by a commercial health insurance policy. Place an "X" in the box that identifies the member's relationship to the policyholder.
7	Insured's Address	Not Required	
8	Reserved for NUCC Use		
9	Other Insured's Name	Conditional	If field 11d is marked "YES," enter the insured's last name, first name and middle initial.
9a	Other Insured's Policy or Group Number	Conditional	If field 11d is marked "YES," enter the policy or group number.
9b	Reserved for NUCC Use		
9c	Reserved for NUCC Use		
9d	Insurance Plan or Program Name	Conditional	If field 11d is marked "YES," enter the insurance plan or program name.
10a-c	Is Patient's Condition Related to?	Conditional	When appropriate, place an "X" in the correct box to indicate whether one (1) or more of the services described in field 24 are for a condition or injury that occurred on the job, as a result of an auto accident or other.

CMS Field #	Field Label	Field is?	Instructions
10d	Reserved for Local Use		
11	Insured's Policy, Group or FECA Number	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's policy number as it appears on the ID card. Only complete if field 4 is completed.
11a	Insured's Date of Birth, Sex	Conditional	Complete if the member is covered by a Medicare health insurance policy. Enter the insured's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. Place an "X" in the appropriate box to indicate the sex of the insured.
11b	Other Claim ID	Not Required	
11c	Insurance Plan Name or Program Name	Not Required	
11d	Is there another Health Benefit Plan?	Conditional	When appropriate, place an "X" in the correct box. If marked "YES," complete 9, 9a and 9d.
12	Patient's or Authorized Person's signature	Required	Enter "Signature on File," "SOF," or legal signature. If there is no signature on file, leave blank or enter "No Signature on File." Enter the date the claim form was signed.
13	Insured's or Authorized Person's Signature	Not Required	

CMS Field #	Field Label	Field is?	Instructions
14	Date of Current Illness Injury or Pregnancy	Conditional	<p>Complete if information is known. Enter the date of illness, injury or pregnancy (date of the last menstrual period), using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Enter the applicable qualifier to identify which date is being reported.</p> <p>431 Onset of Current Symptoms or Illness</p> <p>484 Last Menstrual Period</p>
15	Other Date	Not Required	
16	Date Patient Unable to Work in Current Occupation	Not Required	
17	Name of Referring Physician	Not Required	
18	Hospitalization Dates Related to Current Service	Conditional	<p>Complete for services provided in an inpatient hospital setting. Enter the date of hospital admission and the date of discharge using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014. If the member is still hospitalized, the discharge date may be omitted. This information is not edited.</p>
19	Additional Claim Information	Conditional	<p>LBOD</p> <p>Use to document the Late Bill Override Date for timely filing.</p>
20	Outside Lab? \$ Charges	Conditional	<p>Complete if <u>all</u> laboratory work was referred to and performed by an outside laboratory. If this box is checked, no payment will be made to the physician for lab services. Do</p>

CMS Field #	Field Label	Field is?	Instructions
			not complete this field if <u>any</u> laboratory work was performed in the office. Practitioners may not request payment for services performed by an independent or hospital laboratory.
21	Diagnosis or Nature of Illness or Injury	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM (DOS 10/1/15 and after) 9 ICD-9-CM (DOS 9/30/15 and before)
22	Medicaid Resubmission Code	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field. 7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	Prior Authorization	Not Required	
24	Claim Line Detail	Information	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. Do not enter more than six lines of information on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). Do not file continuation claims (e.g., Page 1 of 2).

CMS Field #	Field Label	Field is?	Instructions
24A	Dates of Service	Required	<p>The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date, and two digits for the year. Example: 010115 for January 1, 2015</p> <div><div>From</div><div>To</div><div><div>01</div><div>01</div><div>15</div><div></div><div></div><div></div></div></div> <p>Or</p> <div><div>From</div><div>To</div><div><div>01</div><div>01</div><div>15</div><div>01</div><div>01</div><div>15</div></div></div> <p>Span dates of service</p> <div><div>From</div><div>To</div><div><div>01</div><div>01</div><div>15</div><div>01</div><div>31</div><div>15</div></div></div> <p>Practitioner claims must be consecutive days.</p> <p><u>Single Date of Service:</u> Enter the six digit date of service in the "From" field. Completion of the "To" field is not required. Do not spread the date entry across the two fields.</p> <p><u>Span billing:</u> Permissible if the same service (same procedure code) is provided on consecutive dates.</p> <p>Supplemental Qualifier</p> <p>To enter supplemental information, begin at 24A by entering the qualifier and then the information.</p> <div><div>ZZ</div><div>Narrative description of unspecified code</div></div> <div><div>N4</div><div>National Drug Codes</div></div> <div><div>VP</div><div>Vendor Product Number</div></div> <div><div>OZ</div><div>Product Number</div></div> <div><div>CTR</div><div>Contract Rate</div></div> <div><div>JP</div><div>Universal/National Tooth Designation</div></div>

CMS Field #	Field Label	Field is?	Instructions
			JO Dentistry Designation System for Tooth & Areas of Oral Cavity
24B	Place of Service	Required	<p>Enter the Place of Service (POS) code that describes the location where services were rendered. The Colorado Medical Assistance Program accepts the CMS place of service codes.</p> <ul style="list-style-type: none"> 03 School 04 Homeless Shelter 05 IHS Free-Standing Facility 06 Provider-Based Facility 07 Tribal 638 Free-Standing 08 Tribal 638 Provider-Based 11 Office 12 Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room Hospital 24 ASC 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Transportation – Land 42 Transportation – Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility

CMS Field #	Field Label	Field is?	Instructions
			52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility – MR 55 Residential Treatment Facility 60 Mass Immunization Center 61 Comprehensive IP Rehab Facility 62 Comprehensive OP Rehab Facility 65 End Stage Renal Dialysis Trtmt Facility 71 State-Local Public Health Clinic 72 Rural Health Clinic 81 Independent Lab 99 Other Unlisted
24C	EMG	Conditional	Enter a "Y" for YES or leave blank for NO in the bottom, unshaded area of the field to indicate the service is rendered for a life-threatening condition or one that requires immediate medical intervention. If a "Y" for YES is entered, the service on this detail line is exempt from co-payment requirements.
24D	Procedures, Services, or Supplies	Required	Enter the HCPCS procedure code that specifically describes the service for which payment is requested. All procedures must be identified with codes in the current edition of Physicians Current Procedural Terminology (CPT). CPT is updated annually. HCPCS Level II Codes The current Medicare coding publication (for Medicare crossover claims only). Only approved codes from the current CPT or HCPCS publications will be accepted.

CMS Field #	Field Label	Field is?	Instructions
24D	Modifier	Not Required	
24E	Diagnosis Pointer	Required	<p>Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis.</p> <p>At least one diagnosis code reference letter must be entered.</p> <p>When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow.</p> <p>This field allows for the entry of four characters in the unshaded area.</p>
24F	\$ Charges	Required	<p>Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.</p> <p>Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply.</p> <p>The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed.</p> <p>Submitted charges cannot be more than charges made to non-Colorado Medical Assistance Program covered individuals for the same service.</p> <p>Do not deduct Colorado Medical Assistance Program co-payment or commercial</p>

CMS Field #	Field Label	Field is?	Instructions
			insurance payments from the usual and customary charges.
24G	Days or Units	Required	Enter the number of services provided for each procedure code. Enter whole numbers only - do not enter fractions or decimals.
24H	EPSDT/Family Plan	Conditional	<p>EPSDT (shaded area) For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows:</p> <p>AV Available - Not Used S2 Under Treatment ST New Service Requested NU Not Used</p> <p>Family Planning (unshaded area) If the service is Family Planning, enter "Y" for YES or "N" for NO in the bottom, unshaded area of the field.</p>
24I	ID Qualifier	Not Required	
24J	Rendering Provider ID #	Required	In the shaded portion of the field, enter the eight-digit Colorado Medical Assistance Program provider number assigned to the <u>individual</u> who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic. NOTE: When billing a paper claim form, do not use the individual's NPI.
25	Federal Tax ID Number	Not Required	

CMS Field #	Field Label	Field is?	Instructions
26	Patient's Account Number	Optional	Enter information that identifies the patient or claim in the provider's billing system. Submitted information appears on the Provider Claim Report (PCR).
27	Accept Assignment?	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	Total Charge	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	Amount Paid	Conditional	Enter the total amount paid by Medicare or any other commercial health insurance that has made payment on the billed services. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use		
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	<p>Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent.</p> <p>A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent.</p> <p>An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent.</p> <p>Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date, and two digits for the year. Example: 070114 for July 1, 2014.</p> <p>Unacceptable signature alternatives:</p>

CMS Field #	Field Label	Field is?	Instructions
			<p>Claim preparation personnel may not sign the enrolled provider's name.</p> <p>Initials are not acceptable as a signature.</p> <p>Typed or computer printed names are not acceptable as a signature.</p> <p>"Signature on file" notation is not acceptable in place of an authorized signature.</p>
32	32- Service Facility Location Information 32a- NPI Number 32b- Other ID #	Conditional	<p>Complete for services provided in a hospital or nursing facility in the following format:</p> <p>1st Line Name</p> <p>2nd Line Address</p> <p>3rd Line City, State, and Zip Code</p> <p>32a- NPI Number</p> <p>Enter the NPI of the service facility (if known).</p> <p>32b- Other ID #</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the service facility (if known).</p> <p>The information in field 32, 32a, and 32b is not edited.</p>
33	33- Billing Provider Info & Ph # 33a- NPI Number 33b- Other ID #	Required	<p>Enter the name of the individual or organization that will receive payment for the billed services in the following format:</p> <p>1st Line Name</p> <p>2nd Line Address</p> <p>3rd Line City, State and Zip Code</p> <p>33a- NPI Number</p> <p>Enter the NPI of the billing provider</p> <p>33b- Other ID #</p> <p>Enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.</p>

Late Bill Override Date

For electronic claims, a delay reason code must be selected and a date must be noted in the "Claim Notes/LBOD" field.

Valid Delay Reason Codes

- 1 Proof of Eligibility Unknown or Unavailable
- 3 Authorization Delays
- 7 Third Party Processing Delay
- 8 Delay in Eligibility Determination
- 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 11 Other



The Late Bill Override Date (LBOD) allows providers to document compliance with timely filing requirements when the initial timely filing period has expired. Colorado Medical Assistance Program providers have 120 days from the date of service to submit a claim. For information on the 60-day resubmission rule for denied/rejected claims, see the General Provider Information manual on the [Billing Manuals](#) web page of the Department's website.

Making false statements about timely filing compliance is a misrepresentation and falsification that, upon conviction, makes the individual who prepares the claim and the enrolled provider subject to a fine and imprisonment under state and/or federal law.

Billing Instruction Detail	Instructions
LBOD Completion Requirements	<ul style="list-style-type: none"> • Electronic claim formats provide specific fields for documenting the LBOD. • Supporting documentation must be kept on file for six years. • For paper claims, follow the instructions appropriate for the claim form being used. <ul style="list-style-type: none"> ➤ <i>UB-04</i>: Occurrence code 53 and the date are required in FL 31-34. ➤ <i>CMS 1500</i>: Indicate "LBOD" and the date in box 19 – Additional Claim Information. ➤ <i>2006 ADA Dental</i>: Indicate "LBOD" and the date in box 35 – Remarks
Adjusting Paid Claims	If the initial timely filing period has expired and a previously submitted claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day

Billing Instruction Detail	Instructions
	<p>follow-up period was paid and now needs to be adjusted, resulting in additional payment to the provider.</p> <p>Adjust the claim within 60 days of the claim payment. Retain all documents that prove compliance with timely filing requirements.</p> <p><i>Note: There is no time limit for providers to adjust paid claims that would result in repayment to the Colorado Medical Assistance Program.</i></p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the payment.</p>
Denied Paper Claims	<p>If the initial timely filing period has expired and a previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was denied.</p> <p>Correct the claim errors and refile within 60 days of the claim denial or rejection. Retain all documents that prove compliance with timely filing requirements.</p> <p>LBOD = the run date of the Colorado Medical Assistance Program Provider Claim Report showing the denial.</p>
Returned Paper Claims	<p>A previously submitted paper claim that was filed within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was returned for additional information.</p> <p>Correct the claim errors and re-file within 60 days of the date stamped on the returned claim. Retain a copy of the returned claim that shows the receipt or return date stamped by the fiscal agent.</p> <p>LBOD = the stamped fiscal agent date on the returned claim.</p>
Rejected Electronic Claims	<p>An electronic claim that was previously entered within the original Colorado Medical Assistance Program timely filing period or the allowed 60 day follow-up period was rejected and information needed to submit the claim was not available to refile at the time of the rejection.</p> <p>Correct claim errors and refile within 60 days of the rejection. Maintain a printed copy of the rejection notice that identifies the claim and date of rejection.</p> <p>LBOD = the date shown on the claim rejection report.</p>

Billing Instruction Detail	Instructions
Denied/Rejected Due to Member Eligibility	<p>An electronic eligibility verification response processed during the original Colorado Medical Assistance Program timely filing period states that the individual was not eligible but the provider was subsequently able to verify eligibility. Read also instructions for retroactive eligibility.</p> <p>File the claim within 60 days of the date of the rejected eligibility verification response. Retain a printed copy of the rejection notice that identifies the member and date of eligibility rejection.</p> <p>LBOD = the date shown on the eligibility rejection report.</p>
Retroactive Member Eligibility	<p>The claim is for services provided to an individual whose Colorado Medical Assistance Program eligibility was backdated or made retroactive.</p> <p>File the claim within 120 days of the date that the individual's eligibility information appeared on state eligibility files. Obtain and maintain a letter or form from the county departments of social services that:</p> <ul style="list-style-type: none"> • Identifies the member by name • States that eligibility was backdated or retroactive • Identifies the date that eligibility was added to the state eligibility system. <p>LBOD = the date shown on the county letter that eligibility was added to or first appeared on the state eligibility system.</p>
Delayed Notification of Eligibility	<p>The provider was unable to determine that the member had Colorado Medical Assistance Program coverage until after the timely filing period expired.</p> <p>File the claim within 60 days of the date of notification that the individual had Colorado Medical Assistance Program coverage. Retain correspondence, phone logs, or a signed Delayed Eligibility Certification form (see Certification & Request for Timely Filing Extension in the Provider Services Forms section) that identifies the member, indicates the effort made to identify eligibility, and shows the date of eligibility notification.</p> <ul style="list-style-type: none"> • Claims must be filed within 365 days of the date of service. No exceptions are allowed. • This extension is available only if the provider had no way of knowing that the individual had Colorado Medical Assistance Program coverage.

Billing Instruction Detail	Instructions
	<ul style="list-style-type: none"> Providers who render services in a hospital or nursing facility are expected to get benefit coverage information from the institution. The extension does not give additional time to obtain Colorado Medical Assistance Program billing information. If the provider has previously submitted claims for the member, it is improper to claim that eligibility notification was delayed. <p>LBOD = the date the provider was advised the individual had Colorado Medical Assistance Program benefits.</p>
Electronic Medicare Crossover Claims	<p>An electronic claim is being submitted for Medicare crossover benefits within 120 days of the date of Medicare processing/payment. (Note: on the paper claim form (only), the Medicare SPR/ERA date field documents crossover timely filing and completion of the LBOD is not required.)</p> <p>File the claim within 120 days of the Medicare processing/payment date shown on the SPR/ERA. Maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Medicare Denied Services	<p>The claim is for Medicare denied services (Medicare non-benefit services, benefits exhausted services, or the member does not have Medicare coverage) being submitted within 60 days of the date of Medicare processing/denial.</p> <p><i>Note: This becomes a regular Colorado Medical Assistance Program claim, not a Medicare crossover claim.</i></p> <p>File the claim within 60 days of the Medicare processing date shown on the SPR/ERA. Attach a copy of the SPR/ERA if submitting a paper claim and maintain the original SPR/ERA on file.</p> <p>LBOD = the Medicare processing date shown on the SPR/ERA.</p>
Commercial Insurance Processing	<p>The claim has been paid or denied by commercial insurance.</p> <p>File the claim within 60 days of the insurance payment or denial. Retain the commercial insurance payment or denial notice that identifies the member, rendered services, and shows the payment or denial date.</p> <p>Claims must be filed within 365 days of the date of service. No exceptions are allowed. If the claim is nearing the 365-day limit and the commercial insurance company has not completed processing, file the claim, receive a denial or rejection, and continue filing in</p>

Billing Instruction Detail	Instructions
	compliance with the 60-day rule until insurance processing information is available. LBOD = the date commercial insurance paid or denied.
Correspondence LBOD Authorization	The claim is being submitted in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific member, claim, services, or circumstances. File the claim within 60 days of the date on the authorization letter. Retain the authorization letter. LBOD = the date on the authorization letter.
Member Changes Providers during Obstetrical Care	The claim is for obstetrical care where the member transferred to another provider for continuation of OB care. The prenatal visits must be billed using individual visit codes but the service dates are outside the initial timely filing period. File the claim within 60 days of the last OB visit. Maintain information in the medical record showing the date of the last prenatal visit and a notation that the member transferred to another provider for continuation of OB care. LBOD = the last date of OB care by the billing provider.

CMS 1500 SBIRT Claim Example**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> PICA </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 1. MEDICARE (Medicare #) <input checked="" type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/> </div> <div> 1a. INSURED'S I.D. NUMBER (For Program in Item 1) D444444 </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client, Ima A </div> <div> 3. PATIENT'S BIRTH DATE 10 16 45 M F <input checked="" type="checkbox"/> </div> <div> 4. INSURED'S NAME (Last Name, First Name, Middle Initial) </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) </div> <div> 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> </div> <div> 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME </div> <div> 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10a. RESERVED FOR LOCAL USE </div> <div> 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a and 9d. </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature on File DATE 1/1/15 </div> <div> 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI </div> <div> 15. OTHER DATE MM DD YY QUAL 17b. NPI </div> <div> 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) </div> </div>																																																																																			
<div style="display: flex; justify-content: space-between;"> <div> 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind 0 A. Z71.41 B. C. D. E. F. G. H. I. J. K. L. </div> <div> 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER </div> </div>																																																																																			
<table border="1"> <thead> <tr> <th>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY</th> <th>B. PLACE OF SERVICE EMG</th> <th>C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DATES OF USE</th> <th>H. ICD-9-CM PROC. CODE</th> <th>I. ID. QUAL</th> <th>J. RENDERING PROVIDER ID #</th> </tr> </thead> <tbody> <tr> <td>01 01 15 01 01 15 23</td> <td></td> <td>H0049</td> <td>A</td> <td>29 68 1</td> <td></td> <td></td> <td></td> <td>12345678 0123456789 12345678 0123456789</td> </tr> <tr> <td>01 01 15 01 01 15 23</td> <td></td> <td>H0050</td> <td>A</td> <td>64 75 1</td> <td></td> <td></td> <td></td> <td>NPI</td> </tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>NPI</td></tr> </tbody> </table>												24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATES OF USE	H. ICD-9-CM PROC. CODE	I. ID. QUAL	J. RENDERING PROVIDER ID #	01 01 15 01 01 15 23		H0049	A	29 68 1				12345678 0123456789 12345678 0123456789	01 01 15 01 01 15 23		H0050	A	64 75 1				NPI									NPI									NPI									NPI									NPI									NPI
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATES OF USE	H. ICD-9-CM PROC. CODE	I. ID. QUAL	J. RENDERING PROVIDER ID #																																																																											
01 01 15 01 01 15 23		H0049	A	29 68 1				12345678 0123456789 12345678 0123456789																																																																											
01 01 15 01 01 15 23		H0050	A	64 75 1				NPI																																																																											
								NPI																																																																											
								NPI																																																																											
								NPI																																																																											
								NPI																																																																											
								NPI																																																																											
<div style="display: flex; justify-content: space-between;"> <div> 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. Optional 27. ACCEPT ASSIGNMENT? (For opt. date, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 94 43 29. AMOUNT PAID \$ 30. Paid for NUCC Use </div> <div> 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.) SIGNED Signature DATE 1/1/15 </div> <div> 32. SERVICE FACILITY LOCATION INFORMATION ABC SBIRT Clinic 100 Any Street Any City </div> <div> 33. BILLING PROVIDER INFO & PH # () a. 1234567890 b. 04567890 </div> </div>																																																																																			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Resources:

Face-to-face training, consultation, and other education opportunities:

improvinghealthcolorado.org

SBIRT Training online at: CMEcorner.com/SBIRT

SBIRT Training online at: sbirttraining.com

Ensuring Solutions to Alcohol Problems: ensuringsolutions.org

CO Division of Behavioral Health treatment directory:

colorado.gov/TreatmentDirectory/interview1.jsf

Alcohol Screening/Guidelines: alcoholscreening.org/Learn-More.aspx

Health TeamWorks website with SBIRT Guidelines, CRAFFT, AUDIT, and DAST:

healthteamworks.org/guidelines/sbirt.asp

SBIRT Revisions Log

Creation Date	Additions/Changes	Pages	Made by
10/01/2010	Manual Created	All	ad, vr
06/09/2011	Manual Revised	All	ad
09/09/2011	Edited & Verified links Updated TOC Checked claim example	Throughout 1 & 2 32	jg
09/19/2011	Accepted updates Updated TOC Re-did claim example	Throughout 1 & 2 32	jg
12/06/2011	Replaced 997 with 999 Replaced wpc-edi.com/hipaa with wpc-edi.com/ Replaced Implementation Guide with Technical Report 3 (TR3)	5 3 3	ss
06/28/2013	Manual Revised	8, 10 & 11, 15, 31	AS
08/05/2013	Updated: Program Overview Billing Information FQHC-CPT Requirements Diagnosis Codes Revised electronic billing and referred to CO-1500	3 3 10 12 4	cc
08/06/2013	Accepted changes Re-formatted Re-did claim example Updated TOC	Throughout Throughout 28 i-ii	Jg
05/22/2014	Removed references to the Primary Care Physician Program	Throughout	Mm
8/22/14	Replaced all CO 1500 references with CMS 1500	Throughout	ZS
8/22/14	Updated Professional Claim Billing Instructions section with CMS 1500 information.		ZS
8/22/14	Replaced all client references to client	Throughout	ZS
8/25/2014	Revised all web links to reflect the Department's new website	Throughout	MM

12/08/2014	Removed Appendix H information, added Timely Filing document information	26	mc
12/31/2014	Revised all content, added NCCI policy	Throughout	AW
2/18/15	Revised all references of client to member, replaced "home page" with web page, corrected spelling throughout, included the words procedure codes in front of the five-digit codes, changed reference to the Colorado Medical Assistance Program Web Portal (Web Portal) phrase for first reference.	Throughout	JH
3/13/15	Added section for NCCI Edits for SBIRT	6	AW
03/13/2015	TOC update and minor formatting	Throughout	bl
04/28/2015	Changed the word unshaded to shaded	24J	Bl
7/27/2015	Changed ICD-9 codes to ICD-10. Replaced references to ICD-9 with ICD-10.	7, 8, 9	JH
8/25/15	Added column for prior authorization to procedure code tables. Verified in MMIS if PA required or not. Verified no mention of CareWebQI/ColoradoPAR in manual	7,8 Throughout	JH
09/09/2015	Removed blank space, updated TOC, and accepted changes	Throughout	bl

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occurred.